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**THE INSTITUTIONAL WORK OF CREATING AND IMPLEMENTING SOCIAL
IMPACT BONDS**

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THE INSTITUTIONAL WORK OF CREATING AND IMPLEMENTING SOCIAL IMPACT BONDS

Abstract

Social Impact Bonds (SIBs) are a new and increasingly popular public policy tool which link payments to outcomes thus, in theory, transferring risk from governments to private investors. This paper draws on the concepts of institutional work and discursive institutionalism to analyse how a SIB influenced the rules, norms and decisions of key actors. It identifies two dominant discourses. One focused on addressing the social determinants of health, the other on creating the financial structure needed to run a SIB. These discourses were congruent at a macro-policy level, but tensions emerged between them at the meso and micro levels. This exemplifies the interdependence of structure and agency in institutional work and the mediating role which discourse plays. It also suggests that the effectiveness of a SIB depends not just on whether it achieves its outcome targets but also on whether it can institute new sets of practices and thinking.

Keywords: Social Impact Bonds; Social Prescribing; Outcomes-based commissioning; Discursive institutionalism; Impact investment; Social investment

Social Impact Bonds (SIBs) have emerged as a new policy tool, designed to link the outcomes of social interventions to payments with risk, in theory, being borne by private investors rather than through public funds. In 2010, the UK's Ministry of Justice established the first SIB, sparking global interest from policy makers, investors, social enterprises and others. Despite emerging research on SIBs (Tan et al, 2015; Edmiston and Nicholls, 2017; Fox et al, 2011; Gustafsson-Wright et al, 2015), there remains a dearth of granular empirical detail about the establishment, operational running and 'SIB effect' (i.e. how SIBs effect practices of those involved) within wider systemic contexts (Fraser et al, 2018). The majority of studies have focused on understanding high-level outcomes of SIBs or on the systems of metrics and payments rather than examining the detailed complex set of interactions between key personnel.

SIBs work by bringing together social investors (e.g. philanthropists, foundations), commissioners (i.e. the state) and social purpose organisations (e.g. voluntary sector, social enterprises) to facilitate a particular social intervention. Investors provide the working capital under the premise that when the outcomes of that intervention are reached (e.g. reduced homelessness) then the commissioner will repay the investor at an agreed rate of return. The outcomes are independently evaluated using a variety of methodologies with the interventions and contracts being managed by a 'Special Purpose Vehicle' (SPV) – a particular organisation that manages the contract. Thus, SIBs are a complex new policy tool involving a multitude of actors yet limited empirical detail is known.

To gather such detail, Warner (2013) argues the need for an institutionalist approach to SIBs that shows evolving rules, norms and practices because these enduring features affect the decision-making of key actors. We build upon institutional theory by examining the specific discursive nature of a SIB (Schmidt, 2008) to understand the 'SIB effect' (Fraser et al, 2018).

We primarily draw from the concept of institutional work: understood in terms of agency and practices aimed at creating, maintaining, and disrupting institutions (Lawrence et al, 2011). Drawing from these perspectives, we highlight that this process occurs across macro (commissioner level), meso (inter-organisational) and micro (care level) aspects of the SIB programme.

The research focus is a SIB funded programme located in a Northern England city which sought to address the social determinants of health (SDH¹). We identify and explain institutional work through two strands of discourse; the first focusing on the activity for significant scaling (i.e. greater and long-term outreach to clients) of a social care practice to address the social determinants of health within the National Health Service (NHS); the second focuses on the work needed to create and run a SIB. We examine complementarities and tensions between these two strands to explore the nature of the ‘SIB effect’.

Background Literature

Institutional environments are ‘characterized by the elaboration of rules and requirements to which individual organizations must conform if they are to receive support and legitimacy’ (Scott 1995: 132). Institutional theory has increasingly focussed on agency and change (Coule and Patmore, 2013; Lounsbury, 2007) with the literature recently embracing the concept of institutional work. Lawrence and Suddaby (2011: 52) define this as ‘the practices of individual and collective actors aimed at creating, maintaining, and disrupting institutions’. This offers a granular recognition of how individuals work to re-arrange elements of their institutional environment. By drawing from this concept within our SIB context, we are interested in the

¹ The World Health Organization (2008) defines social determinants of health as factors as ‘access to health care, schools and education, conditions of work and leisure, homes, communities, towns or cities – and their chances of leading a flourishing life’ (p,1)

role of SIBs (and the actors involved) in working to influence create, maintain or disrupt institutional frameworks as a means to enact a particular social intervention.

Discursive institutionalism has adopted a similar view of agency (Schmidt, 2008), presenting the view that new ideas are conveyed interactively through discourse; what is said by particular actors, to whom, how and why. Key dimensions are cognitive, pertaining to recipes and guidelines for action as well as normative, reflecting shared expectations and values to actions. Actors use their 'foreground discursive abilities' (e.g. communication of new ideas) to change or maintain these elements of institutions (Schmidt, 2010). It is the purposive action of institutional work, playing out through discourse, which frames this study. This can be formal (i.e. setting up new structures, processes) or informal in intent (i.e. changing cultures, expectations) with the work itself being normative or cognitive. SIBs are relevant to this framing because they propose a new set of approaches to fund and support particular types of public services. At a policy level, Fraser et al. (2018) emphasise the public sector reform narrative as a central element of SIBs, suggesting that their focus on outcomes lead to new forms of change across different aspects of the system (e.g. healthcare) such as improving innovation in service provision. Dowling and Harvie (2014) present this narrative as an emerging movement towards the financialisation of social value in public service delivery and is echoed by McHugh et al, (2013) who suggest this represents a neo-liberal shift in public service delivery.

Similarly, prior research also highlights how, through SIBs, a potential close number of ideals, values and tools from private sector management have been imported (Tan et al, 2015). By using techniques more akin to a business and market based approaches of revenue maximization to address social problems, such organisations espouse a mixture of values from the for-profit and not-for-profit world (Nicholls, 2010). However, such a private sector

management approach may induce negative effects associated with performance management (Lowe and Wilson, 2017). Edmiston and Nicholls (2017) highlight the data collection requirements of SIBs and the ‘administrative burden’ for service providers coupled with extensive micro-management to enable attainment of successful outcomes (Fox and Albertson, 2011). Here, the SIB mechanism is influential in shaping norms around expectations associated with individual roles through a renewed focus on ‘business-like’ approaches.

On one hand, the literature has focused on SIBs from the point of view of policy development and has been largely critical. On the other hand, it has discussed SIBs as a potential change agent through a rise of an ‘entrepreneurial approach’ to social change (Dowling, 2017). This view of agency is also reflected in the idea that SIBs help to improve collaboration and innovation (Arena et al, 2016; Nicholls and Tomkinson, 2015), although scepticism exists concerning the scope of this claim (Giacomantonio, 2017; Sinclair et al., 2014). The agency view is similarly echoed by Maier et al, (2017) who argue that such multi-stakeholder collaboration can engender culture change and thus may be one enduring feature. As Bengo and Calderini (2016) suggest, SIBs may only be more feasible where cultural and ideological barriers are lower, for example, where delivery organizations are seen as more entrepreneurial and with the requisite managerial skills.

In this paper we ask: What kind of institutional work is required for the development and operation of a SIB? What are the consequences of this type of work? This leads us to consider the roles that people adopt, their work habits, social norms, what is perceived to represent an appropriate course of action, and how that is represented through the emerging discourse of change. The aforementioned SIB literature is largely conceptual in nature but does pinpoint SIBs as a potential change agent. However, the lack of empirical detail weakens our understanding of this ‘SIB effect’ (Fraser et al, 2018). Our framing of institutional work and

the underpinning discourse allows us to speculate about the wider systemic implications of SIBs and to consider that actors play a key role in efforts to drive institutional change.

Methods

The research focuses on SDH, an intervention which seeks to address the social determinants of health by enabling people to build new relationships and practices via a programme of social prescribing². One of the key aspects of the SDH programme is the creation, within the service delivery, of a paid care role who builds a relationship with the client and enables them to connect with a range of relevant local services. We will call this role the ‘Care Connector’. SDH began development as a SIB programme through a coalition instigated by a local voluntary sector support agency in 2011. The commissioner for the SIB programme is the local Clinical Commissioning Group (CCG). The investor is one of the main actors in the social investment field, and the programme has received development resources, and on-going grant support from central government and charitable funders.

SDH began operations in April 2015. Over the course of the seven year CCG contract, it plans to engage over 11,000 beneficiaries. The impact is attributed and payments are generated and paid on the achievement of agreed outcome metric targets, including recruitment to the SDH service and calculations based on reductions in secondary care costs. The latter is evaluated by observing hospital referrals in one part of the city as a ‘control group’ (i.e. a group of individuals who have not received this particular intervention) against those who have received the SDH intervention (NAO 2015). The main payments are based on the use of a measurement tool which records and scores improvements in a beneficiaries’ well-being as agreed with a Care Connector (MacKeith, 2011). SDH has been very successful in its first year

² As defined by Dayson (2017: 399): Social prescribing is a catch-all term for non-medical services and referral pathways developed with the aim of preventing worsening health for people with long-term health conditions and reducing the number and intensity of costly interventions in urgent or specialist care.

of operation. It hit ambitious referral targets, and over-achieved in terms of improvements to the well-being scores.

This paper adopts a single case study research design, drawing primarily from interviews with key actors. In the first round in August 2015, we conducted 13 interviews with the purpose of looking back at the setting-up of the SIB and looking forward at the anticipated effects of it. Exploring the history of the SIB provided an opportunity to learn about the long-run institutional story of the healthcare context, service provision and funding environment. In the second round in summer 2016, we conducted a further 9 interviews with the key participants of the first year of the SIB's operations. This was augmented with secondary material – the early proposals and independent evaluations from those funding the development work.

A single case study design is useful in circumstances that relate to new phenomena being studied (Eisenhardt and Graebner, 2007). As in most single case study designs, we adopt a multi-level approach to understand the key actors and relationships within the SIB. This follows the macro, meso and micro conception of nested policy paradigms outlined by Nicholls and Teasdale (2017) emphasising the multi-level nature of policy. This multi-level account of the data emerged as we observed a diverse range of conversations across key actors. As we applied an initial set of themes to the data (Saldana, 2015), it was clear that institutional work was being conducted at a macro-level – pertaining to conversations between key institutional actors in Government, the Clinical Commissioning Group (CCG) and the NHS. This desire for change manifested itself throughout the SIB structure with meso-level institutional work occurring through the multiple interactions of the Special Purpose Vehicle (SPV: a new organisation established to manage the contract) and at the micro-level through the challenges faced by service providers. Our analysis is abductive in nature (Timmermans and Tavory, 2012), in that it was initially inductive but moved back and forth between the data and theory

(deductive) to finalise the analytical structure presented in Figure 2. We highlight the three sites of work and sources of data in the context of the web of interactions and relationships in Figure 1. We anonymise participants but draw from this data across the two rounds of data collection to structure the findings (e.g. P#1, R2).

Insert Figure 1 here

Findings

We disaggregate our findings in SIBs as multi-level – placing emphasis on formal and informal institutional work by key actors across macro, meso and micro levels. Our findings are consistently structured in terms of two strands where discourse (i.e. where ideas are conveyed, adopted or adapted) is represented through (a) expanding work which addresses the social determinants of health and (b) implementing the SIB structure. This is demonstrated in Figure 2 which highlights the codes ascribed to institutional work across the three levels of analysis and within the two strands of institutional work and associated discourse³. The green arrows represent congruence in these two streams whilst the red shows a tension.

Insert Figure 2 here

Formal Institutional Work

Macro: Influencing commissioner practice

There are two elements to the macro-level institutional work used by the actors who established the SIB. The first (a) element was the desire, on behalf of one of the key actors, to expand the role of care programmes which address the ‘social determinants of health’ (P#2. R1) within the

³ Excerpts of relevant data can be accessed at: <https://institutionalworksibs.wordpress.com/>

healthcare system in the city and was based on a detailed long-term analysis. For approximately 20 years, this actor had used numerous small funding pots to establish health programmes which piloted various aspects of the programme, but had been unable to persuade various health commissioners to commission these programmes using ‘mainstream’ resources. The previous lack of success was attributed to not having evidence that SDH interventions achieved sufficient benefits and cost savings within the ‘medical model’ of healthcare, which was the dominant conceptual framework used by commissioners (P#2, R1).

From this perspective, the desired change of the formal institutional work was that the CCG *should* commission programmes which tackled the social determinants of health as part of their mainstream provision: ‘no more pilots’ (P#2, R1) as one of the key instigators of the programme described. This can be identified as formal institutional work, involving the creation of a new commissioned programme, including the creation of new formal structures such as the SPV, yet the discourse is normative based on a view of what commissioners *should* be doing. Whilst the case for a new formal programme was part of a broader challenge that key actors sought to change the culture of commissioning (the informal work). Through our discourse lens, this represents a challenge to the underpinning ‘philosophy’ (Schmidt, 2008) of macro-scale commissioning work.

This work was partially achieved when SDH was commissioned by the CCG, using the SIB mechanism. Key actors believed the SIB vehicle was a crucial mechanism which enabled this achievement. Whilst the Payment by Results element of the contract between the CCG and SDH enabled the CCG to be assured that it would only pay for the SDH programme if it were a proven success within their existing ‘medical model’. This allowed the CCG to manage the risk of commissioning an ‘unproven’ intervention (P#2, R1, P#3, R1). Furthermore, the nature of the data collected by the SDH programme would enable the case for this type of

intervention to be proven (or not), and this could inform future commissioning decisions. The SIB therefore provided a helpful way to work around to the problems that SDH instigators had experienced with the commissioning of such activity.

The second element of macro-level formal institutional work concerns the development and acceptance of SIBs as a mechanism to fund healthcare interventions (b). This was a key driver of change for other actors involved in the development of SDH (P#8, P#4, P#7, R1). These actors were concerned that the funding landscape for voluntary sector organisations was changing, as a result of significant, and long-term cuts to public expenditure, and that this threatened the future of voluntary sector health and social care activity in the city.

The formal institutional work of these actors was therefore to change the procurement processes of the CCG to enable a SIB to be commissioned in this field of practice, which would then enable SIBs to be commissioned in other areas of practice. They were successful in achieving this aim, in that the CCG commissioned SDH as a SIB, and during the development phase of the SIB, the CCG's rules governing their own behaviour in commissioning NHS contracts were successfully challenged (P#3, R1). Furthermore, other public bodies in the city have begun discussions concerning potential SIB programmes.

We can see therefore that at the macro-level, there was significant convergence between the two elements of formal institutional work or what Schmidt (2008) suggests is a kind of 'coordinative discourse' between key individuals to initiate change. The interests of those seeking to develop SDH, and those seeking to develop a SIB aligned. The SIB funding mechanism, based on upfront resources provided by others, combined with a Payment by Results contract, enabled the CCG to commission a service which addressed the social

determinants of health and the development process for SDH successfully challenged the rules regarding the role that the CCG could play in commissioning future SIB activity.

However, the alignment of these two pieces of institutional work collapsed over time. Those who instigated SDH as a means to expand SDH-type provision in the city were successful in ways they did not anticipate. SDH was commissioned to work in one part of the city only. The Local Authority and CCG put resources into other social determinants of health programmes in other parts of the city, as well as in neighbouring cities (P#2, P#15, R2). Whilst demonstrating successful institutional work in one sense, the recognition and expansion of the model, undermined the SIB experiment through the planned ‘control group’ also having interventions which SDH was planning to use to demonstrate its effectiveness (see section below).

Meso: Formalising roles and reporting the ‘right’ evidence

The formal, meso-level institutional work to expand SDH-type provision contained a number of elements (a). It involved taking the Care Connector practice which had been developed and established within one organisation over the previous 20 years and formalising it so that it could be undertaken by a range of organisations (P#2, P#8, P#7, R1). This emerged in terms of the development of work specifications that formed the basis of a procurement exercise in which voluntary sector organisations submitted applications to deliver the SDH service, and then through into Care Connector job specifications.

The SDH work here concerns the discourse of care for such roles and formalising this so that it can be enacted well by a range of organisations. This formal, meso-level institutional work was successfully undertaken by the emerging SDH Special Purpose Vehicle (SPV). This was deemed to be important because it expanded the Care Connector model beyond the initial

organisation which had developed it, and into a range of voluntary and private sector health and social care delivery organisations. The procurement exercise also helped to legitimise the emerging SDH programme in the eyes of the broader voluntary-sector in the city by giving a range of organisations the opportunity to bid to deliver the work (P#7, R1).

The formal, meso-level institutional work required by the SIB element focused mainly on developing appropriate performance management mechanisms (b). These were required to enable the SPV and the investors to collect and analyse performance data, and thereby receive payment from investors and analyse the performance of the different delivery organisations. The practices are represented here through efforts to get actors to make sense of how to do this type of contract (the CCG) and the performance management associated with producing the data for this (service delivery organisations). The complexity associated with this within a SIB model reveals how the SPV looks to comply with the rules and procedures of the SIB. They ensure that contractual obligations are being met and that the ‘right’ evidence is being used for this (P#10, R2).

Initially, this work seemed to be partially successful. At first, providers reported that they were generally happy with the metrics and indicators that were being used to measure their performance (P#12, R1), and they were similar to metrics that they would have chosen themselves. However, there were also significant tensions between the institutional work required to create the SIB, and that required to expand a programme which tackled the social determinants of health. We can see this at the meso-level through tension between the requirements of the SIB to focus the programme only on those for whom reliable ‘impact’ data could be collected and the judgement of GPs as to who would benefit from this programme’s approach. As part of the development phase, consultation was undertaken with GPs to help determine who the programme should target. GPs identified a range of people that they thought

would benefit from the programme. This identified need covered a wide range of conditions and incorporated both those currently living with those conditions, and those at risk of developing them in future.

As an example, GPs identified patients with musculoskeletal conditions as one of the key target populations who would significantly benefit from the programme, and as a set of people who were costing the NHS most in terms of supporting them to manage those conditions (P#2 R1). However, the target-setting requirements of the SIB meant that who the programme could select for SDH interventions was the focus of ongoing negotiation. It subsequently became clear that the SIB funding meant that SDH programme intervention could only work with those conditions which represented a distinct category in the Quality and Outcomes Framework (QOF) disease register. This would make an adequate return on investment based on the existing secondary care price list (NHS Tariff), as this information was required in order to generate an effective 'control group', and so be able calculate the financial impact that the SIB funded programme had made. Given that there was no existing category for musculoskeletal conditions, SDH was unable to target this group.

This requirement of the SIB performance management mechanism had three negative effects on the institutional work required to expand programmes to tackle the social determinants of health. Firstly, it prevented the programme being able to support groups which could have best helped demonstrate the case for this approach to commissioners. Secondly, it meant that the original prevention/early intervention focus of the SDH programme became diluted as the requirements of the payment mechanisms meant that the focus had to be on patient groups where evidence for the effects of the intervention was available to meet the proof of cost savings requirements. Thirdly, it made it more difficult for the programme to develop effective relationships with GPs (and thus to secure referrals) because GPs felt that the SDH

was not focussed on those they had identified as being in the most need (P#12, R1). These elaborate Dowling's (2017) critique concerning the reality of whether cost savings can actually be achieved through SIBs and reinforces the critique by McHugh et al, (2013) which highlights the over simplification of outcomes that SIBs seem to produce.

Furthermore, there was a significant tension between the macro-level institutional work of expanding the social determinants of health programme and the meso-level creation of the performance management mechanism by which the SPV could have its performance (and financial returns) calculated. This tension was so severe that the successful expansion of the social determinants work in the city undermined the mechanism by which SDH was supposed to be paid, as we shall now explore.

For SIBs to operate in the manner in which they were designed, a SIB-funded programme should be able to identify the attributable difference which that particular set of interventions has made (NAO 2015). For SDH, this meant that it planned to develop a control-group of similar people with long term conditions in another part of the city. The idea was that by analysing the difference in the use of unplanned secondary care between those that received SDH support, and those in the other part of the city who had not, SDH would be able to identify the difference it had made. This measurement was to be the basis on which 70% of payments to SDH were to be made (P#3, R1). The Local Authority and CCG resourced the creation of other programmes to address the social determinants of health in the area of the city where the control cohort was supposed to be taking place, thus undermining the establishment of a meaningful control group (P#2, R2).

Micro: Role and data production requirements

The formal, micro-level work required to institutionalise the expansion of SDH-type activity manifest in two ways (a) how the provider organisations interpreted and enacted the Care Connector role, and (b) how they developed and enacted their own data recording mechanisms, above and beyond that required by the SIB.

This first set of institutional work was not without its challenges (a). Whilst the different providers shared formal documentation of the Care Connector role, how they conveyed the discourse of care through this role was very different. One of the providers interpreted the role primarily as a signposting function. They encouraged their Care Connectors to form light-touch relationships, primarily based on signposting clients to appropriate activities, for fear of creating a dependency on that relationship (P#14, R1). Other providers interpreted the role of Care Connector as requiring a much greater depth of relationship between client and Care Connector (P#12, R1, R2). This difference resulted in significant differences in the caseloads which Care Connectors could accommodate, and on-going disagreement between providers about the nature of the work (P#10, R2).

The providers also had a second set of formal, micro-level work to undertake: to develop the data collection practice which would enable them to reflect on the effectiveness of their own care practice. We know that this is different from the data required for SIB reporting purposes, because one of the providers chose to record data against additional metrics, as they felt that the SIB data was not sufficient to enable them to reflect on their practice (P#12, R2). Providers also reported that, if they were free to choose how to use the recording tools given to them, they would use them differently. For example, they would use a well-being metric to record client progress at time intervals chosen by the worker, based on their understanding of

client need, rather than at the rigid time-intervals demanded by the SDH performance indicators.

The formal, micro-level work to institutionalise the SIB (b) is manifest through the evidence that service delivery organisations are required to generate to meet their contractual obligations. This evidence feeds into the SIB system of metrics and payments at the meso level and providing macro level support to the viability of the idea of the SDH model. Whilst the meso level is concerned with how the SPV manages the complexities between investors, the CCG and the providers, this level is concerned with how these contractual requirements link to what the providers do at the micro level i.e. their practices within their respective organisations. The key challenge for such provider organisations seemed to relate to whether they can align the work they do with the data the contracts oblige them to collect.

As identified by Joy and Shields (2013), the experience of providers suggests that the process of generating evidence to meet the performance indicators set by SDH distorted practice, was resource intensive, stressful (P#12, R2) and encouraged ‘creaming’ of clients – working with those who are easiest to help (P#2, R2). There were also indications of ‘teaching to the test’ activity which enables targets to be met, but which does not address the wider problem which the programme seeks to address (P#12, R2). This gaming is also consistent with findings from the outcomes-based performance literature (Lowe and Wilson, 2015).

In addition, the providers had a number of reservations about how the data from their reporting was being interpreted for contract management. In particular, they had serious concerns about whether the data they were generating for the information system was an accurate reflection of the work they were doing (P#13, R2). This led to concerns that the

onerous data driven nature of the exercise reduced the time Care Connectors had to develop relationships with clients (P#13, R2).

Providers didn't necessarily feel that collecting data was unhelpful but they came to the view that the data required by the SDH programme was unhelpful and inaccurate. Some providers actually collected additional data to facilitate a performance management conversation with the SPV manager (P#11, R2) and with GPs. The type of data they were collecting was also not seen as useful in a learning sense and couldn't be used to inform practice but just enforce the contract (P#13, R2). This creates an interesting contrast with the original rhetoric of those who developed the SIB, who expected it to offer 'robust' services through more-effective data analysis (P#1, 2, 4 & P#8, R1).

We can see, therefore, tension between the practices enacted by the providers in order to formally institutionalise the SIB at a micro-level, and those required to formally institutionalise SDH-type activity at a micro level. The pressure of referral targets led, in some cases, to people being enrolled in the programme because they were easy to help, rather than those in need (P#2, R2). In other cases, it led to people being enrolled in the programme simply because they could be reached via an initial phone call, irrespective of whether they were interested in further participation (P#12 R2). Furthermore, there was tension between the data production which was required to institutionalise SDH, and that required by the SIB.

Informal Institutional Work

Macro: Introducing new cognitive frameworks

The informal, macro-level work required to expand SDH-type activity concerned a change in attitudes and norms amongst commissioners about the value of work which addressed the social determinants of health (a). Thus, it sought to change the discourse around the most relevant

health interventions. In this context, the instigators of SDH were seeking to create a social model of health provision rather than a purely medical one – the logic being that one needs to address the underlying social causes of health in addition to current services (P#2, R1)

Part of this work required changing the perceptions of commissioners about their role in developing people's broad sense of wellbeing. Some commissioners reported that they were uneasy about funding the SDH programme because as health commissioners it was not their job to fund patient 'happiness' (P#3, R1). In an attempt to change this attitude, those developing SDH commissioned a review of research which sought to identify a causal connection between activities which promoted a broad sense of patient wellbeing and 'hard' medical outcomes (P#2, P#7, R1).

The informal, macro-level work to create a SIB was seeking a different cultural change (b). The institutional work in this respect centred on the discourse of making the voluntary sector more 'business-like' (P#7, R1). More specifically, to understand outcome-based contracting mechanisms and the associated risks as small to medium sized organizations (P#2, R1). Similar to the formal version, the informal macro-level institutional work of expanding SDH and creating culture-change in the voluntary sector seem to complement one another. Embracing the SIB model of funding was an opportunity to enact at scale a revised model of healthcare which enables social determinants to be understood. This particular SIB acted as a 'prime' for future similar interventions (P#5, R1) that other elements of the system may be able learn from (P#1, R1). The thinking behind the shared risk nature of the SIB model is that it would allow the voluntary sector to experience and experiment with this type of contract without taking on too much financial risk (P#8, R1). Furthermore, the experimental and innovative nature of the SIB funding mechanism appears to have helped overcome

commissioner scepticism about the likely success of SDH in reducing secondary care costs (P#3, R1).

At this point, we can also note the tension between the SDH-supporting and SIB-supporting institutional work at the macro-level, in terms of the relationship *between* the formal and informal institutional work as highlighted in Figure 2. The formal, structural changes required by the SIB supporting work - creating a new payments by results commissioning model which used changes in unplanned hospital admissions as the key payment trigger - reinforced a 'medical model' view of people; it encourages commissioners to view people as units who have particular medical problems which result in hospitalisation. This is at odds with a cultural shift towards an SDH view of people (P#1, R1)

Meso: Complexity and simplicity, sharing and learning

The meso-level of informal institutional work to enact the expansion of SDH-type activity is manifest in terms of creating a culture of sharing and learning within the programme's operation (a). For the commissioners, SDH was a way for them to demonstrate that they were taking the integration of health and social care services seriously (P#3, R1). This informal institutional work can also be seen in the attempts by the SPV to develop a 'sharing' and 'learning' culture between the different provider organisations, so that practice improves across the four organisations (P#10, R2; P#13, R2).

The meso-level of informal institutional work to create a SIB relates to the operationalization of the 'business-like' culture being cultivated with service providers and fed from the performance requirements of the CCG and the social investor (b). It is here that we observe how the relevant actors think, handle and manage the risk and uncertainty associated with the SIB through performance management. We identify one consistent thread throughout

the multi-layered pressures: the assertion from each actor that, from their perspective, the world is complex and nuanced, but that they need the world of other actors to be simple, and expressed solely in terms of key performance metrics.

At the meso-level, the SPV feels the pressure of having to engage with the complexity upwards to the CCG and investors, and downwards to the service providers. However, the direct and indirect effects of the SIB seem to make responding to this complexity more challenging (P#10, R2). This is due to the ways in which the performance management aspects of the SDH programme, both those drawn directly from the SIB funding arrangements, and those performance indicators which seek to embed the ‘business-like’ culture which those creating the SIB demand, seek to replace complexity with the simplicity of achieving targets (or not).

Within each aspect of the performance management culture and discourse, there are instances where those being performance managed assert the complexity of the situation in which they are trying to work, and those who are performance managing demand the simplicity of conversations based on whether people/organisations are producing the required numbers. We see it in the relationship between the SPV and the commissioner, in which the SPV emphasises the complexity of the work (P#2, R2), whilst the commissioner emphasises the simplicity of the agreed targets (P#3, R2). We see this same dynamic played out in the conversations between the SPV and the providers, but this time, because of they are playing different roles in the performance management conversation, this time it is the providers talking about complexity (P#12 R2) and then the SPV insisting on the simplicity of the agreed metrics (P#3, R2).

At the meso-level of informal institutional change, we again see the tension between the two different strands of institutional work being undertaken. In particular, the manager of the SPV described the way in which their performance management role was in conflict with efforts to promote sharing and learning between providers. This manifest in provider resistance to having their organisational culture changed to become more ‘business-like’ (P#10, R2). Again, it is also important to note the tension between the SDH-supporting and SIB-supporting institutional work (this time at the meso-level), in terms of the relationship *between* the formal and informal institutional work. The formal performance management structures created to make the SIB work impacted negatively on the culture of sharing required to make an SDH care programme effective across organisations.

Micro: Culture of care and data reporting

At the micro-level, the informal institutional work required to expand SDH-type activity consisted of two elements: (a) developing teams of Care Connectors with an appropriate culture of care. Managers of delivery teams described this attitude as people who had strong local knowledge, sought empowerment for others, without taking decisions for them, and those who ‘wouldn’t take no for an answer’ (P#13, P#12, R1). The second element (b) consisted of building relationships between the delivery organisations and GPs, who were acting as referral agents for the programme. This process was helped considerably by the long-history of similar activity undertaken by some of the instigators of the SDH programme (P#4, R1).

The informal, micro-level institutional work required to create a SIB manifest in the way that delivery organisations had to develop the ‘business-like’ data recording culture which enabled the SIB to function. This was partly successful, as all the delivery organisations

adopted the required data-recording practices, and one went considerably further, recording a range of data that was not required by the SIB monitoring processes (P#12, R1).

However, there was again tension between the two competing institutional aims: expanding SDH-activity and establishing a SIB. These emerged in terms of the different cultures around data recording and sharing: the SDH-type work required recording data for learning and practice improvement, the SIB required data for contract management purposes with these competing demands leading to problems (P#2, R2). Once more, this can also be seen not just as tension between the SDH-supporting and SIB-supporting informal institutional work, but also as tension between the SIB-supporting formal work and the SDH-supporting informal work. The culture of data-recording is bound up with the structures for data-recording required by the SIB.

Discussion and Conclusion

Despite the growing interest in SIBS (Gustafsson-Wright et al, 2015), there is currently a lack of granular empirical data that enables understanding of the ‘SIB effect’ (Fraser et al, 2018). To do this we have drawn upon the ideas behind institutional work (Lawrence et al, 2011) and discursive institutionalism (Schmidt, 2008) to position the creation and implementation of SIBs as a mechanism that leads to institutional change at macro, meso and micro levels. In our healthcare context, SIBs were only the latest component of a lengthy and complex history of institutional change within localised healthcare settings.

In drawing from the concepts of the informal and formal nature of institutional work, this paper demonstrates the efforts of actors to bring about institutional development through the SIB as well as the unintended consequences associated with this. We identify this through discourse in both: (a) expanding work which addresses the social determinants of health and

(b) implementing the SIB structure. Whilst this seemed a relatively harmonious concept at a macro-level, we observed the emergence of tensions when this manifest itself at the meso and micro level. Demonstrating the effect that the SIB seems to have on delivery organisations who are typically embedded in a set of practices and cultures that can be at odds with how the SIB worked (Joy and Shields, 2013) which produced an over simplification of outcome focus and reporting (McHugh et al, 2013). This is also congruent with the ‘gaming’ of outcome data that we found in the SDH programme, which has also been seen in other SIB programmes (Edmiston and Nicholls, 2017). The congruence at macro-level, however, indicates that alignment may be easier to achieve at a policy rather than delivery-level (Maier et al, 2016). In this respect, the requirements of the work to implement a SIB with a finance focus is not always congruent with its setting; a similar set of dynamics is highlighted by Dayson (2017), and Carmel and Harlock (2008) in the voluntary sector.

We offer this as our first theoretical contribution. One way to understand ‘the SIB effect’ is examine the potential congruencies and conflicts between the institutional work required to create the social intervention, and the institutional work required to create the SIB-mechanism itself (Fraser et. al, 2018). This finding highlights the importance of using a framing of formal and informal institutional work which is, in addition, supported by an understanding of the discourse (Schmidt, 2008) which is more effective at recognising the interdependence of structure and agency. This represents an important contribution to the SIB literature which has provided a largely conceptual account of agency (Dowling, 2017; McHugh et al, 2013; Nicholls and Teasdale, 2017). Changes to the formal structures (such as creating newly commissioned programmes) are interdependent with changes to the commissioners’ discourse about what is desirable to commission (a shift from medical to social determinant of health models). Similarly, the formal structure of the performance management rules of the SPV was (both)

created in response to the norms required to implement the culture of 'being business-like' and *in turn* influenced the type of performance management culture of the SDH programme.

It is therefore important to highlight the conflicts *between* the sets of formal and informal institutional work represented in Figure 2. There is a consistent conflicted relationship between the formal structures required to instantiate the SIB and the informal culture of the SDH programme. These conflicts exemplify the interdependence of structure and agency in institutional work and the mediating role of discourse in this process. The structures were made by (often heated and protracted) discourse between different actors who were trying to achieve different institutional ends (SDH-creating and SIB-creating). Thus, the structures themselves ended up shaping both the form and the content of the conversations between the different actors in the programme. We offer this reinforcement of the mediating role of discourse, building on Lawrence et al, (2011), as our second theoretical contribution.

Our findings also indicate areas for policy development. They suggest those instituting SIBs should reflect on the institutional work required to both promote the convergence required in order to instigate a programme and to subsequently stabilise the programme. Considering particular structures or actions in this way will help those making decisions to have better insights about the work needed to develop and institutionalise the components of a SIB funded social intervention and their complex inter-relationships. Our perspective also suggests that the potential for SIBs is unlikely to depend on just the outcome of the project itself (i.e. whether outcome targets were met) or even the wider policy context but also on whether a programme institutes a new set of practices and thinking across macro, meso and micro levels.

In interpreting the findings of this study, it is important to be mindful of the limitations of such an institutionalist approach. Suddaby et al, (2017) offer a criticism of some of the core

components in institutional theory which are seen as increasingly rationalised. Indeed, research in another SIB context may see some of the key actors as less susceptible to some of the pressures we identify. Nonetheless, by looking at the granular detail of institutional work, the convergent and divergent consequences, we are able to empirically bring the agency and discourse of the relevant actors into the explanation of SIB policy and practice.

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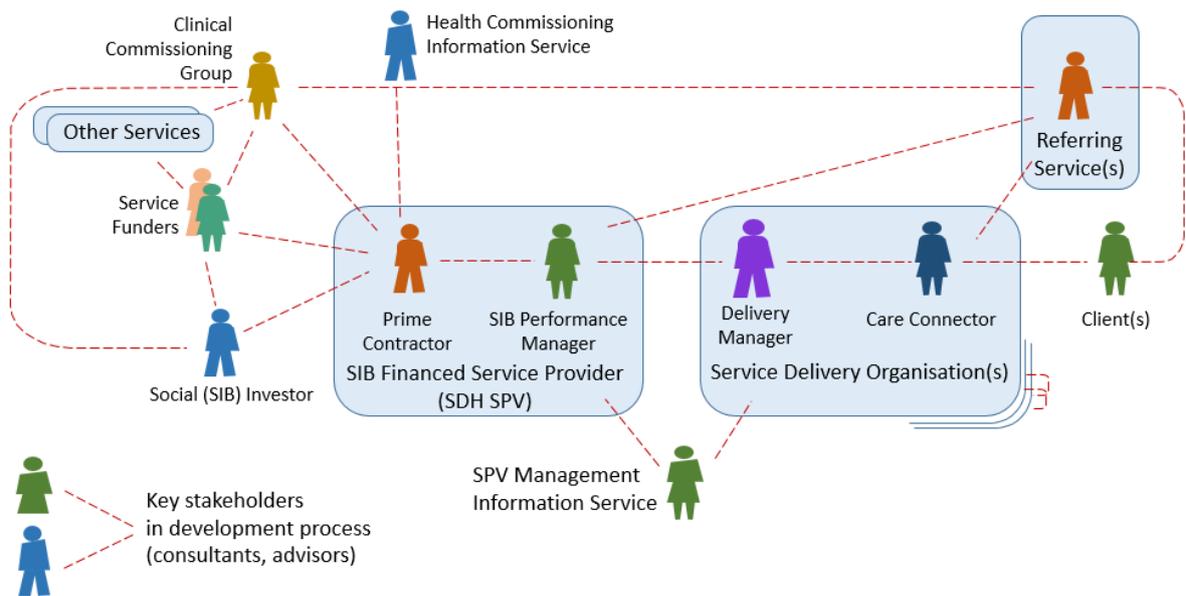


Figure 1: Model of Interactions and Key Stakeholders.

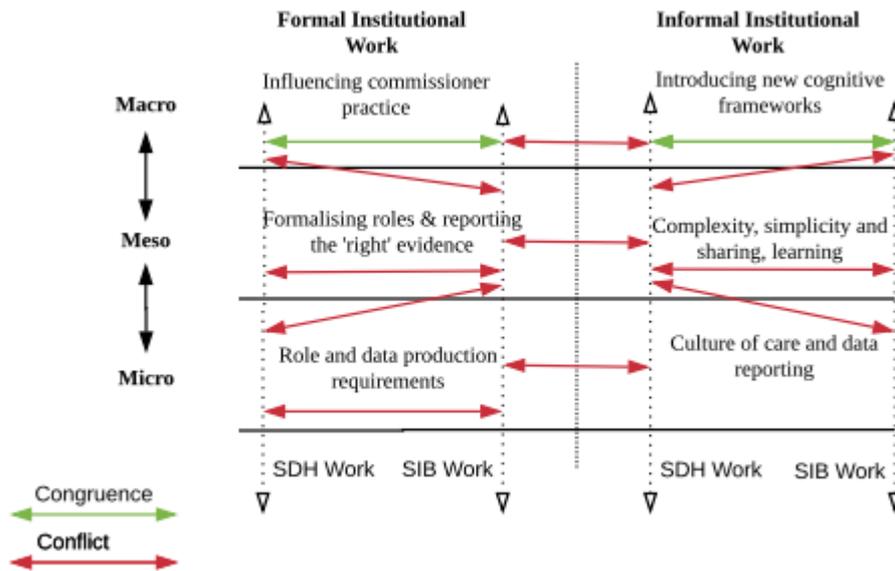


Figure 2: Institutional work of SIBs across macro, meso and micro levels